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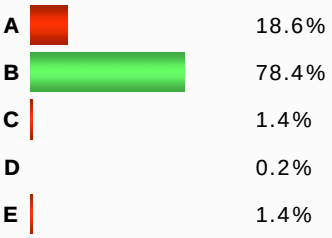
Question 1 of 60

A 56-year-old woman presents with facial asymmetry. Whilst brushing her teeth this morning she noted that the right hand corner of her mouth was drooping. She is generally well but noted some pain behind her right ear yesterday and says her right eye is becoming dry. On examination she has a complete paralysis of the facial nerve on the right side, extending from the forehead to the mouth. Ear, nose and throat examination is normal. Clinical examination of the peripheral nervous system is normal. What is the most likely diagnosis?

- A. Ramsey-Hunt syndrome
- ✓ B. Bell's palsy
- C. Stroke
- D. Multiple sclerosis
- E. Parotid tumour

Next question

Question stats



78.4% of users answered this question correctly

Session score = 100%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

The pain around the ear raises the possibility of Ramsey-Hunt syndrome but this is actually quite common in Bell's palsy - some studies suggest it is seen in 50% of patients. The normal ear exam also goes against this diagnosis.

Bell's palsy

Bell's palsy may be defined as an acute, unilateral, idiopathic, facial nerve paralysis. The aetiology is unknown although the role of the herpes simplex virus has been investigated previously.

Features

- lower motor neuron facial nerve palsy - forehead affected*
- patients may also notice post-auricular pain (may precede paralysis), altered taste, dry eyes

Management

- in the past a variety of treatment options have been proposed including no treatment, prednisolone only and a combination of aciclovir and prednisolone
- following a National Institute for Health randomised controlled trial it is now recommended that prednisolone 25mg bd for 10 days should be prescribed for patients within 72 hours of onset of Bell's palsy. Adding in aciclovir gives no additional benefit
- eye care is important - prescription of artificial tears and eye lubricants should be considered

Prognosis

- if untreated around 15% of patients have permanent moderate to severe weakness

*upper motor neuron lesion 'spares' upper face

Rate question:

Next question

Comment on this question

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Question 2 of 60

You review a 23-year-old woman who presents with a three week history of bilateral nasal obstruction, cough at night and a clear nasal discharge. She had similar symptoms around this time last year and the only history of note is asthma. What is the most likely diagnosis?

- A. Allergic rhinitis ✓
- B. Chronic sinusitis
- C. Nasal hypertrophy secondary to the steroid inhaler
- D. Nasal polyps
- E. Vasomotor rhinitis ✗

Next question

Question stats

A	84.1%
B	1.5%
C	2.3%
D	7.9%
E	4.2%

84.1% of users answered this question correctly

Session score = 50%

Allergic rhinitis

Allergic rhinitis is an inflammatory disorder of the nose where the nose become sensitized to allergens such as house dust mites and grass, tree and weed pollens. It may be classified as follows, although the clinical usefulness of such classifications remains doubtful:

- seasonal: symptoms occur around the same time every year. Seasonal rhinitis which occurs secondary to pollens is known as hay fever
- perennial: symptoms occur throughout the year
- occupational: symptoms follow exposure to particular allergens within the work place

Features

- sneezing
- bilateral nasal obstruction
- clear nasal discharge
- post-nasal drip
- nasal pruritus

Management of allergic rhinitis

- allergen avoidance
- oral or intranasal antihistamines are first line
- intranasal corticosteroids
- course of oral corticosteroids are occasionally needed
- there may be a role for short courses of topical nasal decongestants (e.g. oxymetazoline). They should not be used for prolonged periods as increasing doses are required to achieve the same effect (tachyphylaxis) and rebound hypertrophy of the nasal mucosa may occur upon withdrawal

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries
Allergic rhinitis guidelines

Rate question:

Next question

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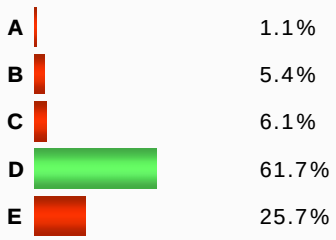
Question 3 of 60

A 7-year-old girl is brought to surgery due to a sore throat. She has a temperature of 39.2ºC and is not eating due to the pain, although she is tolerating fluids. The tonsils are covered in exudate bilaterally. Examination of the ears is unremarkable. Other than supportive treatment, what is the most appropriate management?

- A. Erythromycin for 10 days
- B. Amoxicillin for 7 days
- C. Antibiotics are not indicated
- D. Phenoxymethylpenicillin for 10 days
- E. Phenoxymethylpenicillin for 5 days

Next question

Question stats



61.7% of users answered this question correctly

Session score = 33.3%

This girl has marked systemic upset and should be treated with antibiotics. A 7 or 10 day course of antibiotics is appropriate to ensure eradication of possible *Streptococcus* infection. Phenoxymethylpenicillin is the first-line antibiotic choice in the BNF

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Sore throat

Sore throat encompasses pharyngitis, tonsillitis, laryngitis

Clinical Knowledge Summaries recommend:

- throat swabs and rapid antigen tests should not be carried out routinely in patients with a sore throat

Management

- paracetamol or ibuprofen for pain relief
- antibiotics are not routinely indicated

NICE indications for antibiotics

- features of marked systemic upset secondary to the acute sore throat
- unilateral peritonsillitis
- a history of rheumatic fever
- an increased risk from acute infection (such as a child with diabetes mellitus or immunodeficiency)
- patients with acute sore throat/acute pharyngitis/acute tonsillitis when 3 or more Centor criteria are present

The Centor criteria* are as follows:

- presence of tonsillar exudate
- tender anterior cervical lymphadenopathy or lymphadenitis
- history of fever

- absence of cough

If antibiotics are indicated then either phenoxymethylpenicillin or erythromycin (if the patient is penicillin allergic) should be given. Either a 7 or 10 day course should be given

*if 3 or more of the criteria are present there is a 40-60% chance the sore throat is caused by Group A beta-haemolytic *Streptococcus*

Rate question:

Next question

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Question 4 of 60

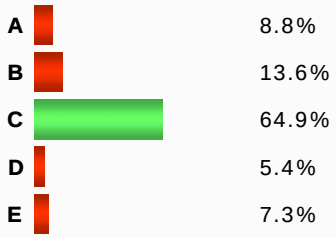
A 14-year-old male presents to surgery with a 3 day history of a sore throat. Which one of the following features is not an indication for antibiotic therapy?

- A. Temperature of 39.1ºC
- B. A past history of diabetes mellitus
- ✓ C. Two previous episodes in the past 5 months
- D. Unilateral peritonsillitis on examination
- E. A past history of rheumatic fever

Next question

A temperature of 39.1ºC would indicate marked systemic upset

Question stats



64.9% of users answered this question correctly

Session score = 50%

Sore throat

Sore throat encompasses pharyngitis, tonsillitis, laryngitis

Clinical Knowledge Summaries recommend:

- throat swabs and rapid antigen tests should not be carried out routinely in patients with a sore throat

Management

- paracetamol or ibuprofen for pain relief
- antibiotics are not routinely indicated

NICE indications for antibiotics

- features of marked systemic upset secondary to the acute sore throat
- unilateral peritonsillitis
- a history of rheumatic fever
- an increased risk from acute infection (such as a child with diabetes mellitus or immunodeficiency)
- patients with acute sore throat/acute pharyngitis/acute tonsillitis when 3 or more Centor criteria are present

The Centor criteria* are as follows:

- presence of tonsillar exudate
- tender anterior cervical lymphadenopathy or lymphadenitis
- history of fever
- absence of cough

If antibiotics are indicated then either phenoxymethylpenicillin or erythromycin (if the patient is penicillin allergic) should be given. Either a 7 or 10 day course should be given

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

*if 3 or more of the criteria are present there is a 40-60% chance the sore throat is caused by Group A beta-haemolytic *Streptococcus*

Rate question:

Next question

Comment on this question

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Question 5 of 60

A 40-year-old woman presents with recurrent episodes of vertigo associated with a feeling or 'fullness' and 'pressure' in her ears. She thinks her hearing is worse during these attacks. Clinical examination is unremarkable. What is the most likely diagnosis?

- ✓ A. Meniere's disease
- B. Benign paroxysmal positional vertigo
- C. Acoustic neuroma
- D. Cholesteatoma
- E. Somatisation

Next question

Question stats

A	86.3%
B	9%
C	2.3%
D	0.8%
E	1.7%

86.3% of users answered this question correctly

Session score = 60%

Meniere's disease

Meniere's disease is a disorder of the inner ear of unknown cause. It is characterised by excessive pressure and progressive dilation of the endolymphatic system. It is more common in middle-aged adults but may be seen at any age. Meniere's disease has a similar prevalence in both men and women.

Features

- recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom
- a sensation of aural fullness or pressure is now recognised as being common
- other features include nystagmus and a positive Romberg test
- episodes last minutes to hours
- typically symptoms are unilateral but bilateral symptoms may develop after a number of years

Natural history

- symptoms resolve in the majority of patients after 5-10 years
- some patients may be left with hearing loss
- psychological distress is common

Management

- ENT assessment is required to confirm the diagnosis
- patients should inform the DVLA. The current advice is to cease driving until satisfactory control of symptoms is achieved
- acute attacks: buccal or intramuscular prochlorperazine. Admission is sometimes required
- prevention: betahistine may be of benefit

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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Question 6 of 60

A 3-year-old boy is brought to surgery. His mum reports that he has been complaining of a sore left ear for the past 2-3 weeks. This morning she noticed some 'green gunge' on his pillow. On examination his temperature is 37.8ºC. Otoscopy of the right ear is normal. On the left side the tympanic membrane cannot be visualised as the ear canal is full with a yellow-green discharge. What is the most appropriate action?

- A. Review in 2 weeks
- B. Admit to paediatrics
- C. Advise olive oil drops followed by ear syringing
- D. Urgent referral to ENT
- ✓ E. Amoxicillin + review in 2 weeks

Next question

This boy is likely to have had an acute otitis media with perforation.

Perforated tympanic membrane

The most common cause of a perforated tympanic membrane is infection. Other causes include barotrauma or direct trauma.

A perforated tympanic membrane may lead to hearing loss depending on the size and also increase the risk of otitis media.

Management

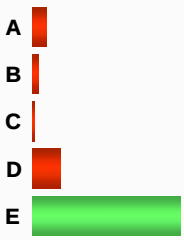
- no treatment is needed in the majority of cases as the tympanic membrane will usually heal after 6-8 weeks. It is advisable to avoid getting water in the ear during this time
- it is common practice to prescribe antibiotics to perforations which occur following an episode of acute otitis media. NICE support this approach in the 2008 Respiratory tract infection guidelines
- myringoplasty may be performed if the tympanic membrane does not heal by itself

Rate question:

Next question

Comment on this question

Question stats



74.5% of users answered this question correctly

Session score = 66.7%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

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Question 7 of 60

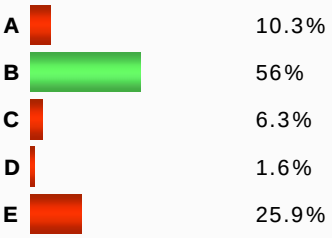
A 34-year-old man is found to have impacted ear wax on the left-side. Which one of the following preparations is it least suitable to prescribe?

- A. Sodium bicarbonate 5%
- B. Docusate sodium 5%
- C. Almond oil
- D. Olive oil
- E. Sodium chloride 0.9%

Next question

Docusate sodium 5% is found in some proprietary preparations but is listed in the BNF as being less suitable for prescription.

Question stats



56% of users answered this question correctly

Session score = 57.1%

Ear wax

Ear wax is a normal physiological substance which helps protect the ear canal. Impacted ear wax is extremely common and may cause a variety of symptoms including:

- pain
- loss of hearing
- tinnitus
- vertigo

The main treatment options in primary care are ear drops or irrigation ('ear syringing'). Treatment should not be given if a perforation is suspected. The following drops may be used:

- olive oil
- sodium bicarbonate 5%
- sodium chloride 0.9%
- almond oil

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries
Ear wax guidelines

Rate question:

Next question

Comment on this question

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Questions 8 to 10 of 60

Theme: Deafness

A Acute suppurative otitis media
B Presbycusis
C Meniere's disease
D Drug ototoxicity
E Otitis externa
F Congenital rubella infection
G Acoustic neuroma
H Glue ear
I Otosclerosis
J Cholesteatoma

For each one of the following scenarios please select the most likely diagnosis:

8. A 36-year-old man presents with recurrent episodes of right-sided tinnitus, hearing loss and vertigo. These episodes typically last between 10-30 minutes. He also describes a 'full' sensation in his right ear. Otoscopy is unremarkable and the cranial nerve examination is normal.

Meniere's disease

Symptoms with an acoustic neuroma tend to be more progressive rather than episodic.

9. A 31-year-old man presents with bilateral hearing loss and tinnitus. There is a family history of similar problems. Examination of the tympanic membranes is unremarkable. Audiometry shows bilateral conductive hearing loss.

Otosclerosis

10. A 2-year-old boy is brought in by his mother due to concerns about his hearing and delayed speech. She has noticed problems for the past three months. You can see from the notes that he has had frequent courses of amoxicillin for otitis media in the past. There is no evidence of excessive ear wax on examination.

Glue ear

Question stats

Average score for registered users:

8	85.7%
9	77.1%
10	88.2%

Session score = 70%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Next question

Deafness

The most common causes of hearing loss are ear wax, otitis media and otitis externa. The table below details some of the characteristic features of other causes:

Presbycusis	Presbycusis describes age-related sensorineural hearing loss. Patients may describe difficulty following conversations Audiometry shows bilateral high-frequency hearing loss
Otosclerosis	Autosomal dominant, replacement of normal bone by vascular spongy bone. Onset is usually at 20-40 years - features include: • conductive deafness • tinnitus • tympanic membrane - 10% of patients may have a 'flamingo tinge', caused by hyperaemia • positive family history
Glue ear	Also known as otitis media with effusion • peaks at 2 years of age • hearing loss is usually the presenting feature (glue ear is the commonest cause of conductive hearing loss and elective surgery in childhood) • secondary problems such as speech and language delay, behavioural or balance problems may also be seen
Meniere's disease	More common in middle-aged adults • recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom • a sensation of aural fullness or pressure is now recognised as being common • other features include nystagmus and a positive Romberg test • episodes last minutes to hours
Drug ototoxicity	Examples include aminoglycosides (e.g. Gentamicin), furosemide, aspirin and a number of cytotoxic agents
Noise damage	Workers in heavy industry are particularly at risk Hearing loss is bilateral and typically is worse at frequencies of 3000–6000 Hz
Acoustic neuroma	Features can be predicted by the affected cranial nerves

(more correctly called vestibular schwannomas)	• cranial nerve VIII: hearing loss, vertigo, tinnitus • cranial nerve V: absent corneal reflex • cranial nerve VII: facial palsy Bilateral acoustic neuromas are seen in neurofibromatosis type 2

Rate question:

Next question

Comment on this question

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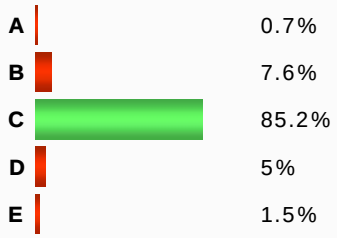
Question 11 of 60

A 59-year-old man presents with a severe pain deep within his right ear. He feels dizzy and reports that the room 'is spinning'. Clinical examination shows a partial facial nerve palsy on the right side and vesicular lesions on the anterior two-thirds of his tongue. What is the most likely diagnosis?

- A. Meniere's disease
- B. Herpes zoster ophthalmicus
- ✓ C. Ramsay Hunt syndrome
- D. Acoustic neuroma
- E. Trigeminal neuralgia

Next question

Question stats



85.2% of users answered this question correctly

Session score = 72.7%

Ramsay Hunt syndrome

Ramsay Hunt syndrome (herpes zoster oticus) is caused by the reactivation of the varicella zoster virus in the geniculate ganglion of the seventh cranial nerve.

Features

- auricular pain is often the first feature
- facial nerve palsy
- vesicular rash around the ear
- other features include vertigo and tinnitus

Management

- oral aciclovir and corticosteroids are usually given

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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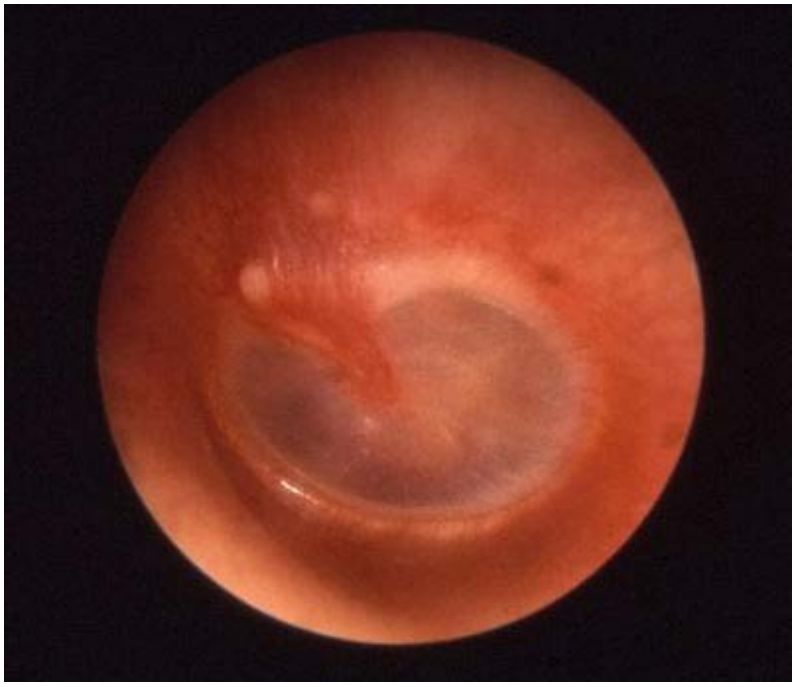
Question 12 of 60

A 6-year-old boy is brought to surgery. His mother says he has been complaining of left sided otalgia for the past three days. Otoscopy demonstrates the following:



What is the most likely diagnosis?

- A. Acute otitis media with perforation
- B. Cholesteatoma
- C. Glue ear
- D. Normal tympanic membrane
- ✓ E. Acute otitis media

Next question

Question stats

A	4.9%
B	1.8%
C	15.5%
D	22.7%
E	55.1%

55.1% of users answered this question correctly

Session score = 75%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

NICE
2008 Respiratory tract infection guidelines

Otitis media

Following the 2008 NICE guidelines on respiratory tract infections antibiotics are not routinely recommended. NICE recommends however that they should be considered in the following situations:

- children younger than 2 years with bilateral acute otitis media
- children with otorrhoea who have acute otitis media

Rate question:

Next question

Comment on this question

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Question 13 of 60

A 37-year-old man presents with nasal obstruction and loud snoring. He has noticed these symptoms get gradually worse for the past two months. His left nostril feels blocked whilst his right feels clear and normal. There is no history of epistaxis and he is systemically well. On examination a large nasal polyp can be seen in the left nostril. What is the most appropriate action?

- A. Reassure + provide patient information leaflet on nasal polyps
- B. Enquire about cocaine use
- ✓ C. Refer to ENT
- D. Trial of intranasal steroids
- E. Nasal cautery

Next question

Question stats

A	1.2%
B	0.3%
C	72.1%
D	25.9%
E	0.4%

72.1% of users answered this question correctly

Session score = 76.9%

Given that his symptoms are unilateral it is important he is referred to ENT for a full examination.

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Nasal polyps

Around in 1% of adults in the UK have nasal polyps. They are around 2-4 times more common in men and are not commonly seen in children or the elderly.

Associations

- asthma* (particularly late-onset asthma)
- aspirin sensitivity*
- infective sinusitis
- cystic fibrosis
- Kartagener's syndrome
- Churg-Strauss syndrome

Features

- nasal obstruction
- rhinorrhoea, sneezing
- poor sense of taste and smell

Unusual features which always require further investigation include unilateral symptoms or bleeding.

Management

- all patients with suspected nasal polyps should be referred to ENT for a full examination
- topical corticosteroids shrink polyp size in around 80% of patients

*the association of asthma, aspirin sensitivity and nasal polyposis is known as Samter's triad

Rate question:

Next question

Comment on this question

Question 14 of 60

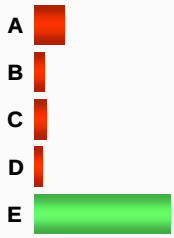
A 45-year-old man presents with dizziness and right-sided hearing loss to his GP. Which one of the following tests would most likely indicate an acoustic neuroma?

- A. Jerky nystagmus
- B. Left homonymous hemianopia
- C. Tongue deviated to the left
- D. Fasciculation of the tongue
- ✓ E. Absent corneal reflex

Next question

Loss of corneal reflex - think acoustic neuroma

Question stats



68.7% of users answered this question correctly

Session score = 78.6%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Acoustic neuroma

Acoustic neuromas (more correctly called vestibular schwannomas) account for approximately five percent of intracranial tumours and 90 percent of cerebellopontine angle

Features can be predicted by the affected cranial nerves

- cranial nerve VIII: hearing loss, vertigo, tinnitus
- cranial nerve V: absent corneal reflex
- cranial nerve VII: facial palsy

Bilateral acoustic neuromas are seen in neurofibromatosis type 2

MRI of the cerebellopontine angle is the investigation of choice

Rate question:

Next question

Comment on this question

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Question 15 of 60

A 21-year-old man presents with halitosis and mouth pain. Examination reveals very poor dental hygiene with bleeding gums and widespread gingival ulceration. He has a temperature of 38.0ºC. You advise him to see a dentist. What other treatment options should be offered?

- A. Paracetamol + oral phenoxymethylpenicillin
- B. Paracetamol + oral phenoxymethylpenicillin + chlorhexidine mouthwash
- C. Paracetamol + chlorhexidine mouthwash
- D. Paracetamol + oral metronidazole + chlorhexidine mouthwash
- E. Paracetamol + oral metronidazole

Next question

This man has acute necrotizing ulcerative gingivitis with systemic upset. Treatment should be commenced whilst he is awaiting to see a dentist.

'Gingivitis and common dental problems' are listed in the curriculum under statement 15.4.

Gingivitis

Gingivitis is usually secondary to poor dental hygiene. Clinical presentation may range from simple gingivitis (painless, red swelling of the gum margin which bleeds on contact) to acute necrotizing ulcerative gingivitis (painful bleeding gums with halitosis and punched-out ulcers on the gums).

If a patient presents with acute necrotizing ulcerative gingivitis CKS recommend the following management:

- refer the patient to a dentist, meanwhile the following is recommended:
- oral metronidazole* for 3 days
- chlorhexidine (0.12% or 0.2%) or hydrogen peroxide 6% mouth wash
- simple analgesia

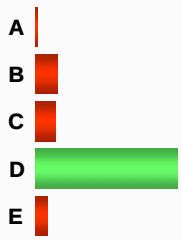
*the BNF also suggest that amoxicillin may be used

Rate question:

Next question

Comment on this question

Question stats



72.1% of users answered this question correctly

Session score = 73.3%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries Gingivitis guidelines

passmedicine.com

Question 16 of 60

Which one of the following is least recognised in patients with Meniere's disease

- A. Aural fullness
- ✓ B. Symptoms triggered by sudden change in head position
- C. Sensorineural hearing loss
- D. Tinnitus
- E. Nystagmus

Next question

Question stats

A	2.8%
B	72%
C	7%
D	1%
E	17.3%

72% of users answered this question correctly

Session score = 75%

Meniere's disease

Meniere's disease is a disorder of the inner ear of unknown cause. It is characterised by excessive pressure and progressive dilation of the endolymphatic system. It is more common in middle-aged adults but may be seen at any age. Meniere's disease has a similar prevalence in both men and women.

Features

- recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom
- a sensation of aural fullness or pressure is now recognised as being common
- other features include nystagmus and a positive Romberg test
- episodes last minutes to hours
- typically symptoms are unilateral but bilateral symptoms may develop after a number of years

Natural history

- symptoms resolve in the majority of patients after 5-10 years
- some patients may be left with hearing loss
- psychological distress is common

Management

- ENT assessment is required to confirm the diagnosis
- patients should inform the DVLA. The current advice is to cease driving until satisfactory control of symptoms is achieved
- acute attacks: buccal or intramuscular prochlorperazine. Admission is sometimes required
- prevention: betahistine may be of benefit

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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Question 17 of 60

A 30-year-old man presents with sneezing, nasal blockage and a constant runny nose. Which one of the following does not have a role in the management of allergic rhinitis?

- A. Oral decongestants ✓
- B. Oral corticosteroids
- C. Intranasal corticosteroids
- D. Oral antihistamines
- E. Intranasal antihistamines

Next question

Question stats

A	51.2%
B	33.3%
C	1.8%
D	1.2%
E	12.5%

51.2% of users answered this question correctly

Session score = 76.5%

Allergic rhinitis

Allergic rhinitis is an inflammatory disorder of the nose where the nose become sensitized to allergens such as house dust mites and grass, tree and weed pollens. It may be classified as follows, although the clinical usefulness of such classifications remains doubtful:

- seasonal: symptoms occur around the same time every year. Seasonal rhinitis which occurs secondary to pollens is known as hay fever
- perennial: symptoms occur throughout the year
- occupational: symptoms follow exposure to particular allergens within the work place

Features

- sneezing
- bilateral nasal obstruction
- clear nasal discharge
- post-nasal drip
- nasal pruritus

Management of allergic rhinitis

- allergen avoidance
- oral or intranasal antihistamines are first line
- intranasal corticosteroids
- course of oral corticosteroids are occasionally needed
- there may be a role for short courses of topical nasal decongestants (e.g. oxymetazoline). They should not be used for prolonged periods as increasing doses are required to achieve the same effect (tachyphylaxis) and rebound hypertrophy of the nasal mucosa may occur upon withdrawal

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries
Allergic rhinitis guidelines

Rate question:

Next question

Comment on this question

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Questions 18 to 20 of 60

Theme: Neck lumps

A Lymphoma
B Tuberculosis
C Reactive lymph nodes
D Cystic hygroma
E Branchial cyst
F Goitre
G Carotid aneurysm
H Pharyngeal pouch
I Thyroglossal cyst
J Cervical rib

For each one of the following scenarios select the most likely diagnosis

18. A 75-year-old man presents with dysphagia and halitosis. On the left side of the neck is a small, fluctuant swelling which gurgles when palpated.

Pharyngeal pouch

19. A 44-year-old woman presents with a neck swelling. She is systemically well. On examination she is noted to have a midline, non-tender neck swelling which moves upwards when she swallows.

Goitre

Patients with a goitre are often euthyroid. A thyroglossal cyst would be unusual at this age.

20. A newborn baby is noted to have a large swelling on the left-side of the neck. On examination a soft, fluctuant and highly transilluminable lump is noted just beneath the skin.

Cystic hygroma

Next question

Question stats

Average score for registered users:

18	88.9%
19	52.2%
20	70.3%

Session score = 80%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Neck lumps

The table below gives characteristic exam question features for conditions causing neck lumps:

Reactive lymphadenopathy	By far the most common cause of neck swellings. There may be a history of local infection or a generalised viral illness
Lymphoma	Rubbery, painless lymphadenopathy The phenomenon of pain whilst drinking alcohol is very uncommon There may be associated night sweats and splenomegaly
Thyroid swelling	May be hypo-, eu- or hyperthyroid symptomatically Moves upwards on swallowing
Thyroglossal cyst	More common in patients < 20 years old Usually midline, between the isthmus of the thyroid and the hyoid bone Moves upwards with protrusion of the tongue May be painful if infected
Pharyngeal pouch	More common in older men Represents a posteromedial herniation between thyropharyngeus and cricopharyngeus muscles Usually not seen but if large then a midline lump in the neck that gurgles on palpation Typical symptoms are dysphagia, regurgitation, aspiration and chronic cough
Cystic hygroma	A congenital lymphatic lesion (lymphangioma) typically found in the neck, classically on the left side Most are evident at birth, around 90% present before 2 years of age
Branchial cyst	An oval, mobile cystic mass that develops between the sternocleidomastoid muscle and the pharynx Develop due to failure of obliteration of the second branchial cleft in embryonic development Usually present in early adulthood
Cervical rib	More common in adult females Around 10% develop thoracic outlet syndrome
Carotid aneurysm	Pulsatile lateral neck mass which doesn't move on swallowing

Rate question:

Next question

Comment on this question

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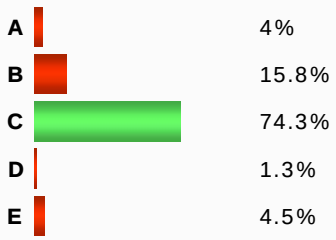
Question 21 of 60

Which one of the following medications is most useful for helping to prevent attacks of Meniere's disease?

- A. Promethazine
- B. Prochlorperazine
- ✓ C. Betahistine
- D. Chlorphenamine
- E. Cinnarizine

Next question

Question stats



74.3% of users answered this question correctly

Session score = 81%

Meniere's disease

Meniere's disease is a disorder of the inner ear of unknown cause. It is characterised by excessive pressure and progressive dilation of the endolymphatic system. It is more common in middle-aged adults but may be seen at any age. Meniere's disease has a similar prevalence in both men and women.

Features

- recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom
- a sensation of aural fullness or pressure is now recognised as being common
- other features include nystagmus and a positive Romberg test
- episodes last minutes to hours
- typically symptoms are unilateral but bilateral symptoms may develop after a number of years

Natural history

- symptoms resolve in the majority of patients after 5-10 years
- some patients may be left with hearing loss
- psychological distress is common

Management

- ENT assessment is required to confirm the diagnosis
- patients should inform the DVLA. The current advice is to cease driving until satisfactory control of symptoms is achieved
- acute attacks: buccal or intramuscular prochlorperazine. Admission is sometimes required
- prevention: betahistine may be of benefit

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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Question 22 of 60

A 52-year-old woman presents to surgery with a two week history of dizziness when she rolls over in bed. She says it feels like the room is spinning around her. Examination of her ears and cranial nerves is unremarkable. Given the likely diagnosis of benign paroxysmal positional vertigo what is the most appropriate management?

- A. Trial of prochlorperazine
- B. Request MRI brain
- C. Advise review by an optician
- ✓ D. Perform Epley manoeuvre
- ✗ E. Trial of cinnarizine

Next question

The majority of GPs would probably not feel confident performing this manoeuvre and may refer the patient to ENT

Benign paroxysmal positional vertigo

Benign paroxysmal positional vertigo (BPPV) is one of the most common causes of vertigo encountered. It is characterised by the sudden onset of dizziness and vertigo triggered by changes in head position

Features

- vertigo triggered by change in head position (e.g. rolling over in bed or gazing upwards)
- may be associated with nausea
- each episode typically lasts 10-20 seconds
- positive Halpike manoeuvre

BPPV has a good prognosis and usually resolves spontaneously after a few weeks to months. Symptomatic relief may be gained by:

- Epley manoeuvre (successful in around 80% of cases)
- teaching the patient exercises they can do themselves at home, for example Brandt-Daroff exercises

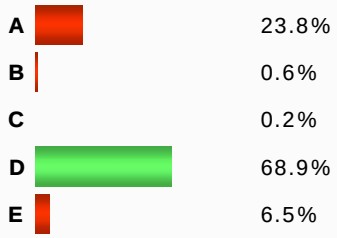
Medication is often prescribed (e.g. Betahistine) but it tends to be of limited value

Rate question:

Next question

Comment on this question

Question stats



68.9% of users answered this question correctly

Session score = 77.3%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries
Benign paroxysmal positional vertigo guidelines

passmedicine.com

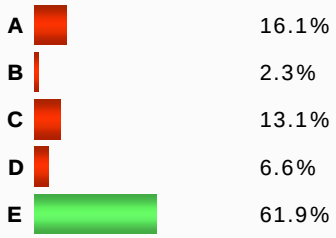
Question 23 of 60

Which one of the following features is least consistent with a diagnosis of otosclerosis?

- A. Tinnitus
- B. Positive family history
- C. Normal tympanic membrane
- D. Conductive deafness
- ✓ E. Onset after the age of 50 years

Next question

Question stats



61.9% of users answered this question correctly

Session score = 78.3%

Otosclerosis

Otosclerosis describes the replacement of normal bone by vascular spongy bone. It causes a progressive conductive deafness due to fixation of the stapes at the oval window. Otosclerosis is autosomal dominant and typically affects young adults

Onset is usually at 20-40 years - features include:

- conductive deafness
- tinnitus
- normal tympanic membrane*
- positive family history

Management

- hearing aid
- stapedectomy

*10% of patients may have a 'flamingo tinge', caused by hyperaemia

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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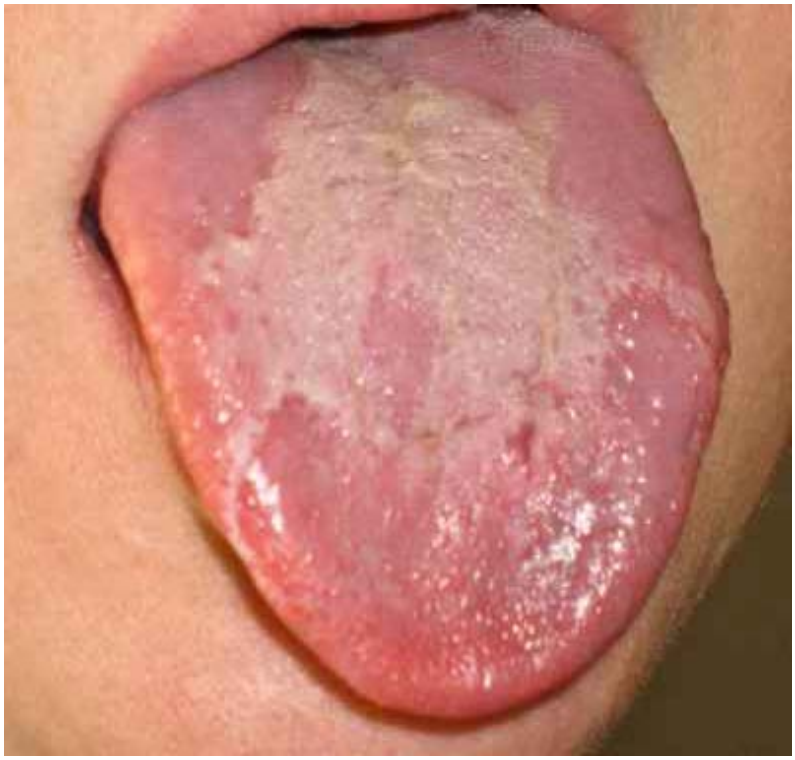
Question 24 of 60

A 25-year-old woman presents as she has noticed an unusual appearance of her tongue. This has been present for the past few weeks. She reports getting a burning sensation when she eats spicy food.



What is the most likely diagnosis?

- A. Strawberry tongue
- ✓ B. Geographic tongue
- C. Hairy leukoplakia
- D. Oral *Candida*
- E. Glossitis likely secondary to anaemia

Next question

Question stats

A	1.5%
B	56.3%
C	9.7%
D	25.4%
E	7.1%

56.3% of users answered this question correctly

Session score = 79.2%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Geographic tongue

Geographic tongue is a benign, chronic condition of unknown cause. It is present in around 1-3% of the population and is more common in females.

Features

- erythematous areas with a white-grey border (the irregular, smooth red

areas are said to look like the outline of a map)
- some patients report burning after eating certain food

Management

- reassurance about benign nature

Rate question:

Next question

Comment on this question

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Question 25 of 60

A 54-year-old woman with a history of hypertension presents to surgery. She has a 4 week history of hoarseness which followed an upper respiratory tract infection 6 weeks ago. She is otherwise fit and well and is a non-smoker. What is the most appropriate management?

- ✓ A. Urgent chest x-ray
- B. Check full blood count
- C. Routine referral to ear, nose and throat
- D. Reassure
- E. Suggest chlorhexidine mouthwash

Next question

An urgent chest x-ray should be performed to direct fast-track referral

Question stats

A	61.7%
B	3.1%
C	20.4%
D	13.8%
E	1.1%

61.7% of users answered this question correctly

Session score = 80%

Hoarseness

Causes of hoarseness include:

- voice overuse
- smoking
- viral illness
- hypothyroidism
- gastro-oesophageal reflux
- laryngeal cancer
- lung cancer

NICE guidelines on referral for suspect cancer suggest:

- refer urgently for chest x-ray patients with hoarseness persisting for more than 3 weeks, particularly smokers aged older than 50 years and heavy drinkers
- if there is a positive finding on chest x-ray, refer urgently to a team specialising in the management of lung cancer
- if the chest x-ray is normal, refer urgently to a team specialising in head and neck cancer

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

NICE
Suspect cancer referral guidelines

Rate question:

Next question

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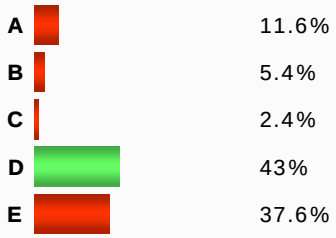
Question 26 of 60

A 61-year-old woman presents with bilateral tinnitus. She reports no change in her hearing or other ear-related symptoms. Ear and cranial nerve examination is unremarkable. Which medication is she most likely to have recently started?

- A. Ciprofloxacin
- B. Nifedipine
- C. Repaglinide
- ✓ D. Quinine
- E. Bendroflumethiazide

Next question

Question stats



43% of users answered this question correctly

Session score = 80.8%

Tinnitus

Causes of tinnitus include:

Meniere's disease	Associated with hearing loss, vertigo, tinnitus and sensation of fullness or pressure in one or both ears
Otosclerosis	Onset is usually at 20-40 years Conductive deafness Tinnitus Normal tympanic membrane* Positive family history
Acoustic neuroma	Hearing loss, vertigo, tinnitus Absent corneal reflex is important sign Associated with neurofibromatosis type 2
Hearing loss	Causes include excessive loud noise and presbycusis
Drugs	Aspirin Aminoglycosides Loop diuretics Quinine

Other causes include

- impacted ear wax
- chronic suppurative otitis media

*10% of patients may have a 'flamingo tinge', caused by hyperaemia

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

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Question 27 of 60

A 68-year-old woman presents with a two month history of electric shock like pains on the right side of her face. She describes having around 10-20 episodes a day which, each lasting for around 30-60 seconds. A recent dental check was normal. Neurological examination is unremarkable. What is the most suitable first-line management?

- A. Amitriptyline
- B. Sodium valproate
- ✓ C. Carbamazepine
- D. Atenolol
- E. Zolmitriptan

Next question

Trigeminal neuralgia - carbamazepine is first-line

Question stats

A	40.5%
B	1.2%
C	56.7%
D	0.3%
E	1.3%

56.7% of users answered this question correctly

Session score = 81.5%

RCGP curriculum

15.7 - Neurological Problems

Knowledge

Curriculum statement

Trigeminal neuralgia

Trigeminal neuralgia is a pain syndrome characterised by severe unilateral pain. The vast majority of cases are idiopathic but compression of the trigeminal roots by tumours or vascular problems may occur

The International Headache Society defines trigeminal neuralgia as:

- a unilateral disorder characterised by brief electric shock-like pains, abrupt in onset and termination, limited to one or more divisions of the trigeminal nerve
- the pain is commonly evoked by light touch, including washing, shaving, smoking, talking, and brushing the teeth (trigger factors), and frequently occurs spontaneously
- small areas in the nasolabial fold or chin may be particularly susceptible to the precipitation of pain (trigger areas)
- the pains usually remit for variable periods

Management

- carbamazepine is first-line*
- failure to respond to treatment or atypical features (e.g. < 50 years old) should prompt referral to neurology

*the 2010 NICE neuropathic pain guidelines recommend using amitriptyline or pregabalin first-line for non-diabetic neuropathic pain., but makes no specific recommendation for trigeminal neuralgia. Due to the amount of evidence supporting carbamazepine in trigeminal neuralgia and its recommendation in

consensus guidelines (including Clinical Knowledge Summaries) the author does not feel that this recommendation should be changed for now

Rate question:

Next question

Comment on this question

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Questions 28 to 30 of 60

Theme: Vertigo

A Acoustic neuroma
B Viral labyrinthitis
C Meniere's disease
D Multiple sclerosis
E Vertebrobasilar ischaemia
F Ramsey-Hunt syndrome
G Benign paroxysmal positional vertigo

For each one of the following scenarios select the most likely diagnosis:

28. A 62-year-old man with a 3 month history of dizziness when he rolls over in bed. Episodes last for about 20 seconds

Benign paroxysmal positional vertigo

29. A 31-year-old female with a 3 week history of vertigo, right ear tinnitus and the sensation of fullness in her right ear

Meniere's disease

Acoustic neuroma is a differential and a MRI may be indicated

30. A 33-year-old with coryzal symptoms presents with a one day history of vertigo and nausea. There is no hearing loss on examination

Viral labyrinthitis

Next question

Question stats

Average score for registered users:

28	94.1%
29	82.6%
30	96.5%

Session score = 83.3%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Vertigo

The table below lists the main characteristics of the most important causes of vertigo

Viral labyrinthitis	• Recent viral infection • Sudden onset • Nausea and vomiting • Hearing may be affected
Vestibular neuritis	• Recent viral infection • Recurrent vertigo attacks lasting hours or days • No hearing loss
Benign paroxysmal positional vertigo	• Gradual onset • Triggered by change in head position • Each episode lasts 10-20 seconds
Meniere's disease	• Associated with hearing loss, tinnitus and sensation of fullness or pressure in one or both ears
Vertebrobasilar ischaemia	• Elderly patient • Dizziness on extension of neck
Acoustic neuroma	• Hearing loss, vertigo, tinnitus • Absent corneal reflex is important sign • Associated with neurofibromatosis type 2

Other causes of vertigo include

- trauma
- multiple sclerosis
- ototoxicity e.g. gentamicin

Rate question:

Next question

Comment on this question

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Question 31 of 60

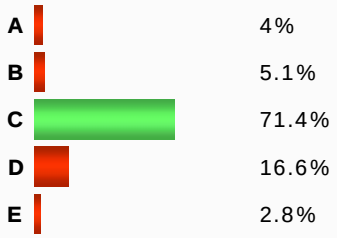
A 34-year-old man complains of a sore throat. Which one of the following is not part of the Centor criteria used to assess the likelihood of a bacterial cause?

- A. Fever
- B. Tender anterior cervical lymphadenopathy
- ✓ C. Duration > 5 days
- D. Absence of cough
- E. Presence of tonsillar exudate

Next question

If 3 or more of the 4 Centor criteria are present there is a 40-60% chance the sore throat is caused by Group A beta-haemolytic *Streptococcus*

Question stats



71.4% of users answered this question correctly

Session score = 83.9%

Respiratory tract infections: NICE guidelines

NICE issued guidance in 2008 on the management of respiratory tract infection, focusing on the prescribing of antibiotics for self-limiting respiratory tract infections in adults and children in primary care

A no antibiotic prescribing or delayed antibiotic prescribing approach is generally recommended for patients with acute otitis media, acute sore throat/acute pharyngitis/acute tonsillitis, common cold, acute rhinosinusitis or acute cough/acute bronchitis.

However, an immediate antibiotic prescribing approach may be considered for:

- children younger than 2 years with bilateral acute otitis media
- children with otorrhoea who have acute otitis media
- patients with acute sore throat/acute pharyngitis/acute tonsillitis when 3 or more Centor criteria are present

The Centor criteria* are as follows:

- presence of tonsillar exudate
- tender anterior cervical lymphadenopathy or lymphadenitis
- history of fever
- absence of cough

If the patient is deemed at risk of developing complications, an immediate antibiotic prescribing policy is recommended

- are systemically very unwell
- have symptoms and signs suggestive of serious illness and/or complications (particularly pneumonia, mastoiditis, peritonsillar abscess, peritonsillar cellulitis, intraorbital or intracranial complications)
- are at high risk of serious complications because of pre-existing comorbidity. This includes patients with significant heart, lung, renal, liver

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

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External links

NICE
2008 Respiratory tract infection guidelines

or neuromuscular disease, immunosuppression, cystic fibrosis, and young children who were born prematurely
- are older than 65 years with acute cough and two or more of the following, or older than 80 years with acute cough and one or more of the following:
- - hospitalisation in previous year
- - type 1 or type 2 diabetes
- - history of congestive heart failure
- - current use of oral glucocorticoids

The guidelines also suggest that patients should be advised how long respiratory tract infections may last:

- acute otitis media: 4 days
- acute sore throat/acute pharyngitis/acute tonsillitis: 1 week
- common cold: 1 1/2 weeks
- acute rhinosinusitis: 2 1/2 weeks
- acute cough/acute bronchitis: 3 weeks

*if 3 or more of the criteria are present there is a 40-60% chance the sore throat is caused by Group A beta-haemolytic *Streptococcus*

Rate question:

Next question

Comment on this question

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Question 32 of 60

A 24-year-old man who is suffering from sinusitis asks about using Sudafed (pseudoephedrine). Which one of the following medications would make the use of Sudafed contraindicated?

- A. Sodium valproate
- ✓ B. Monoamine oxidase inhibitor
- C. Salbutamol
- ✗ D. Triptan
- E. Selective serotonin reuptake inhibitor

Next question

A monoamine oxidase inhibitor combined with pseudoephedrine could potentially cause a hypertensive crisis.

The January 2010 AKT feedback report stated 'Increasingly, patients are encouraged to self-manage conditions, perhaps with advice from a pharmacist. *Candida*tes did not perform well with regard to issues related to over the counter medication, such as side-effects and contraindications.'

Sinusitis

Sinusitis describes an inflammation of the mucous membranes of the paranasal sinuses. The sinuses are usually sterile - the most common infectious agents seen in acute sinusitis are *Streptococcus pneumoniae*, *Haemophilus influenzae* and rhinoviruses.

Predisposing factors include:

- nasal obstruction e.g. Septal deviation or nasal polyps
- recent local infection e.g. Rhinitis or dental extraction
- swimming/diving
- smoking

Features

- facial pain: typically frontal pressure pain which is worse on bending forward
- nasal discharge: usually thick and purulent
- nasal obstruction: e.g. 'mouth breathing'
- post-nasal drip: may produce chronic cough

Management of acute sinusitis

- analgesia
- intranasal decongestants
- oral antibiotics are not normally required but may be given for severe

Question stats

A	5.7%
B	55.6%
C	5.9%
D	25.8%
E	7%

55.6% of users answered this question correctly

Session score = 81.3%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries Sinusitis

presentations. Amoxicillin is currently first-line

Management of recurrent or chronic sinusitis

- treat any acute element as above
- intranasal corticosteroids are often beneficial
- referral to ENT may be appropriate

Rate question:

Next question

Comment on this question

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Question 33 of 60

Which one of the following patients is most likely to have nasal polyps?

- ✓ A. A 40-year-old man
- B. A 40-year-old woman
- C. An 8-year-old girl
- D. An 80-year-old woman
- E. An 8-year-old boy

Next question

Nasal polyps are most common in male adults

Question stats

A	77.7%
B	7.9%
C	2.7%
D	3.2%
E	8.5%

77.7% of users answered this question correctly

Session score = 81.8%

Nasal polyps

Around in 1% of adults in the UK have nasal polyps. They are around 2-4 times more common in men and are not commonly seen in children or the elderly.

Associations

- asthma* (particularly late-onset asthma)
- aspirin sensitivity*
- infective sinusitis
- cystic fibrosis
- Kartagener's syndrome
- Churg-Strauss syndrome

Features

- nasal obstruction
- rhinorrhoea, sneezing
- poor sense of taste and smell

Unusual features which always require further investigation include unilateral symptoms or bleeding.

Management

- all patients with suspected nasal polyps should be referred to ENT for a full examination
- topical corticosteroids shrink polyp size in around 80% of patients

*the association of asthma, aspirin sensitivity and nasal polyposis is known as Samter's triad

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

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Question 34 of 60

You see a 3-year-old boy as a follow-up appointment. Two weeks ago he presented with left-sided otalgia associated with a purulent discharge. You prescribed amoxicillin and arranged to see him today. His mum reports that he is much better and says she has managed to keep the ear dry. On examination of the left side a perforation of the tympanic membrane is noted. What is the most appropriate action?

- A. Advise to keep ear dry and see in a further 4 weeks time ✓
- B. Prescribe gentamicin ear drops to prevent infection + see in a further 6 weeks time
- C. Advise to keep ear dry and see in a further 12 weeks time
- D. Refer to ENT
- E. Prescribe prophylactic dose amoxicillin to prevent infection + see in a further 4 weeks time

Next question

If there is still a perforation when the boy is reviewed in 4 weeks time (i.e. 6 weeks since the perforation occurred) then ENT referral should be considered. Topical gentamicin should never be given to a patient with a perforated tympanic membrane.

Perforated tympanic membrane

The most common cause of a perforated tympanic membrane is infection. Other causes include barotrauma or direct trauma.

A perforated tympanic membrane may lead to hearing loss depending on the size and also increase the risk of otitis media.

Management

- no treatment is needed in the majority of cases as the tympanic membrane will usually heal after 6-8 weeks. It is advisable to avoid getting water in the ear during this time
- it is common practice to prescribe antibiotics to perforations which occur following an episode of acute otitis media. NICE support this approach in the 2008 Respiratory tract infection guidelines
- myringoplasty may be performed if the tympanic membrane does not heal by itself

Rate question:

Next question

Comment on this question

Question stats

A	74.8%
B	0.6%
C	14.5%
D	6.6%
E	3.5%

74.8% of users answered this question correctly

Session score = 82.4%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

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Question 35 of 60

A 60-year-old man is diagnosed with Bell's palsy. What is the current evidenced base approach to the management of this condition?

- A. Refer for urgent surgical decompression
- B. Aciclovir
- C. No treatment
- D. Aciclovir + prednisolone
- ✓ E. Prednisolone

Next question

Eye care is also very important.

Question stats

A	0.3%
B	6.8%
C	5.8%
D	20.1%
E	67.1%

67.1% of users answered this question correctly

Session score = 82.9%

Bell's palsy

Bell's palsy may be defined as an acute, unilateral, idiopathic, facial nerve paralysis. The aetiology is unknown although the role of the herpes simplex virus has been investigated previously.

Features

- lower motor neuron facial nerve palsy - forehead affected*
- patients may also notice post-auricular pain (may precede paralysis), altered taste, dry eyes

Management

- in the past a variety of treatment options have been proposed including no treatment, prednisolone only and a combination of aciclovir and prednisolone
- following a National Institute for Health randomised controlled trial it is now recommended that prednisolone 25mg bd for 10 days should be prescribed for patients within 72 hours of onset of Bell's palsy. Adding in aciclovir gives no additional benefit
- eye care is important - prescription of artificial tears and eye lubricants should be considered

Prognosis

- if untreated around 15% of patients have permanent moderate to severe weakness

*upper motor neuron lesion 'spares' upper face

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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Question 36 of 60

Which one of the following is least recognised as a cause of vertigo?

- A. Gentamicin ✗
- B. Meniere's disease
- C. Acoustic neuroma
- D. Multiple sclerosis
- E. Motor neuron disease ✓

Next question

Question stats

A	13.3%
B	0.9%
C	2%
D	8.9%
E	75%

75% of users answered this question correctly

Session score = 80.6%

Vertigo

The table below lists the main characteristics of the most important causes of vertigo

Viral labyrinthitis	• Recent viral infection • Sudden onset • Nausea and vomiting • Hearing may be affected
Vestibular neuritis	• Recent viral infection • Recurrent vertigo attacks lasting hours or days • No hearing loss
Benign paroxysmal positional vertigo	• Gradual onset • Triggered by change in head position • Each episode lasts 10-20 seconds
Meniere's disease	• Associated with hearing loss, tinnitus and sensation of fullness or pressure in one or both ears
Vertebrobasilar ischaemia	• Elderly patient • Dizziness on extension of neck
Acoustic neuroma	• Hearing loss, vertigo, tinnitus • Absent corneal reflex is important sign • Associated with neurofibromatosis type 2

Other causes of vertigo include

- trauma
- multiple sclerosis
- ototoxicity e.g. gentamicin

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

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Rate question:

Next question

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Question 37 of 60

A 23-year-old man presents with a 4 day history of an itchy and sore right ear. He has recently returned from holiday in Spain. On examination the right ear canal is inflamed but no debris is seen. The tympanic membrane is clearly visible and is unremarkable. What is the most appropriate management?

- A. Topical corticosteroid + aminoglycoside ✓
- B. Topical corticosteroid
- C. Refer to ENT
- D. Topical corticosteroid + clotrimazole
- E. Oral flucloxacillin ✗

Next question

This patient has otitis externa, which commonly develops after swimming on holiday. The first line management is either a topical antibiotic or a combined topical antibiotic and steroid.

Otitis externa

Otitis externa is a common reason for primary care attendance in the UK.

Causes of otitis externa include:

- infection: bacterial (*Staphylococcus aureus*, *Pseudomonas aeruginosa*) or fungal
- seborrhoeic dermatitis
- contact dermatitis (allergic and irritant)

Features

- ear pain, itch, discharge
- otoscopy: red, swollen, or eczematous canal

The recommend initial management of otitis externa is:

- topical antibiotic or a combined topical antibiotic with steroid
- if the tympanic membrane is perforated aminoglycosides should not be used
- if there is canal debris then consider removal
- if the canal is extensively swollen then an ear wick is sometimes inserted

Second line options include

- consider contact dermatitis secondary to neomycin
- oral antibiotics if the infection is spreading
- taking a swab inside the ear canal
- empirical use of an antifungal agent

Question stats

A	58.8%
B	21.6%
C	0.8%
D	11.4%
E	7.4%

58.8% of users answered this question correctly

Session score = 78.4%

RCGP curriculum

15.4 - ENT and Facial Problems

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External links

Clinical Knowledge Summaries
Otitis externa guidelines

Malignant otitis externa is more common in elderly diabetics. In this condition there is extension of infection into the bony ear canal and the soft tissues deep to the bony canal. Intravenous antibiotics may be required.

Rate question:

Next question

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Questions 38 to 40 of 60

Theme: Deafness

A Parkinson's disease
B Presbycusis
C Meniere's disease
D Digoxin induced
E Noise damage
F Amiodarone induced
G Acoustic neuroma
H Furosemide induced
I Vestibular neuritis
J Cholesteatoma

For each one of the following scenarios please select the most likely diagnosis:

38. A 61-year-old woman with a history of cardiac problems develops hearing loss after a prolonged admission in hospital. Drug toxicity is suspected.

Furosemide induced

39. A 78-year-old man complains of difficultly following conversations. His wife says he has the TV turned up too loud. Audiometry shows sensorineural hearing loss at the higher frequencies.

Presbycusis

40. A 37-year-old cello player complains of a three month history of vertigo and hearing loss on the left side. On examination he has an absent corneal reflex on the left eye.

Acoustic neuroma

Next question

Question stats

Average score for registered users:

38	62.2%
39	90.6%
40	92.6%

Session score = 80%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

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Deafness

The most common causes of hearing loss are ear wax, otitis media and otitis externa. The table below details some of the characteristic features of other causes:

Presbycusis	Presbycusis describes age-related sensorineural hearing loss. Patients may describe difficulty following conversations Audiometry shows bilateral high-frequency hearing loss
Otosclerosis	Autosomal dominant, replacement of normal bone by vascular spongy bone. Onset is usually at 20-40 years - features include: • conductive deafness • tinnitus • tympanic membrane - 10% of patients may have a 'flamingo tinge', caused by hyperaemia • positive family history
Glue ear	Also known as otitis media with effusion • peaks at 2 years of age • hearing loss is usually the presenting feature (glue ear is the commonest cause of conductive hearing loss and elective surgery in childhood) • secondary problems such as speech and language delay, behavioural or balance problems may also be seen
Meniere's disease	More common in middle-aged adults • recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom • a sensation of aural fullness or pressure is now recognised as being common • other features include nystagmus and a positive Romberg test • episodes last minutes to hours
Drug ototoxicity	Examples include aminoglycosides (e.g. Gentamicin), furosemide, aspirin and a number of cytotoxic agents
Noise damage	Workers in heavy industry are particularly at risk Hearing loss is bilateral and typically is worse at frequencies of 3000–6000 Hz
Acoustic neuroma (more correctly called vestibular schwannomas)	Features can be predicted by the affected cranial nerves • cranial nerve VIII: hearing loss, vertigo, tinnitus • cranial nerve V: absent corneal reflex • cranial nerve VII: facial palsy Bilateral acoustic neuromas are seen in neurofibromatosis type 2

Rate question:

Next question

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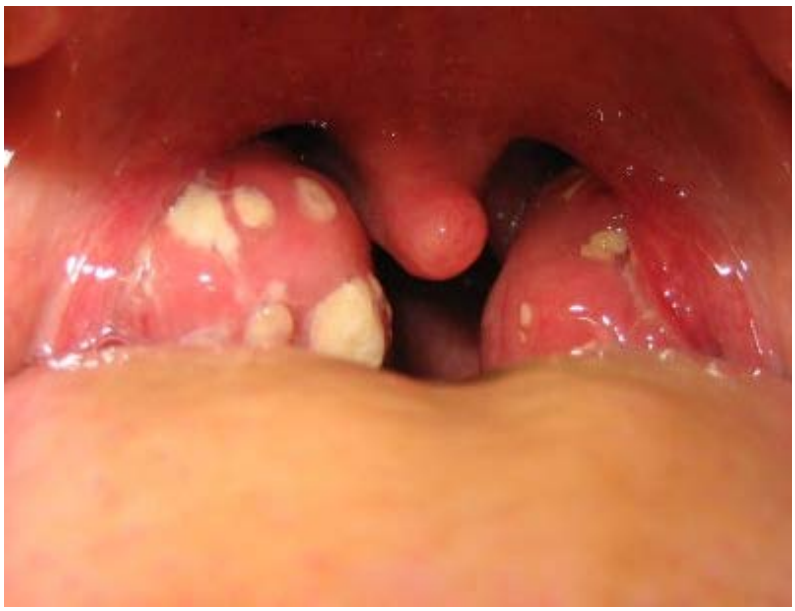
Question 41 of 60

A 41-year-old woman presents with a sore throat. Examination of the throat reveals:



What is the most likely diagnosis?

- A. Tonsillar carcinoma
- B. Peritonsillar abscess (quinsy)
- ✓ C. Acute tonsillitis
- D. Infectious mononucleosis
- E. Retropharyngeal abscess

Next question

Infectious mononucleosis is a possibility but a simple tonsillitis is the most likely diagnosis.

Tonsillitis and tonsillectomy

Complications of tonsillitis include:

- otitis media
- quinsy - peritonsillar abscess
- rheumatic fever and glomerulonephritis very rarely

The indications for tonsillectomy are controversial. NICE recommend that surgery should be considered only if the person meets all of the following criteria

- sore throats are due to tonsillitis (i.e. not recurrent upper respiratory tract

Question stats

A	0.8%
B	14.1%
C	80.9%
D	3.8%
E	0.4%

80.9% of users answered this question correctly

Session score = 80.5%

RCGP curriculum

15.4 - ENT and Facial Problems

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infections)
- the person has five or more episodes of sore throat per year
- symptoms have been occurring for at least a year
- the episodes of sore throat are disabling and prevent normal functioning

Other established indications for a tonsillectomy include

- recurrent febrile convulsions secondary to episodes of tonsillitis
- obstructive sleep apnoea, stridor or dysphagia secondary to enlarged tonsils
- peritonsillar abscess (quinsy) if unresponsive to standard treatment

Complications of tonsillectomy

- primary (< 24 hours): haemorrhage in 2-3% (most commonly due to inadequate haemostasis), pain
- secondary (24 hours to 10 days): haemorrhage (most commonly due to infection), pain

Rate question:

Next question

Comment on this question

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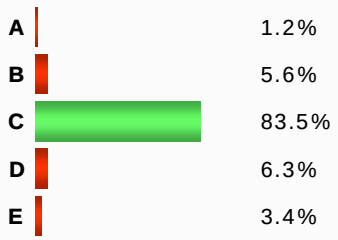
Question 42 of 60

A 71-year-old man presents with two year history of intermittent problems with swallowing. His wife has also noticed he has halitosis and is coughing at night. He has a past medical history of type 2 diabetes mellitus but states he is otherwise well. Of note his weight is stable and he has a good appetite. Clinical examination is unremarkable. What is the most likely diagnosis?

- A. Oesophageal cancer
- B. Hiatus hernia
- C. Pharyngeal pouch
- D. Oesophageal candidiasis
- E. Benign oesophageal stricture

Next question

Question stats



83.5% of users answered this question correctly

Session score = 78.6%

Given the two year history and good health oesophageal cancer is much less likely

Pharyngeal pouch

A pharyngeal pouch is a posteromedial diverticulum through Killian's dehiscence. Killian's dehiscence is a triangular area in the wall of the pharynx between the thyropharyngeus and cricopharyngeus muscles. It is more common in older patients and is 5 times more common in men

Features

- dysphagia
- regurgitation
- aspiration
- neck swelling which gurgles on palpation
- halitosis

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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Question 43 of 60

A 34-year-old woman with recurrent vertigo is referred to ENT and diagnosed with Meniere's disease. What is the most appropriate advice with regards to the DVLA?

- A. Inform the DVLA, cannot drive for 4 weeks from diagnosis
- B. Inform the DVLA, no restriction
- C. Inform the DVLA, cannot drive for one week after each acute episode
- D. No need to inform the DVLA
- ✓ E. Inform the DVLA, cannot drive until satisfactory control of symptoms is achieved

Next question

Question stats

A	0.9%
B	3.2%
C	1.9%
D	8.3%
E	85.7%

85.7% of users answered this question correctly

Session score = 79.1%

Meniere's disease

Meniere's disease is a disorder of the inner ear of unknown cause. It is characterised by excessive pressure and progressive dilation of the endolymphatic system. It is more common in middle-aged adults but may be seen at any age. Meniere's disease has a similar prevalence in both men and women.

Features

- recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom
- a sensation of aural fullness or pressure is now recognised as being common
- other features include nystagmus and a positive Romberg test
- episodes last minutes to hours
- typically symptoms are unilateral but bilateral symptoms may develop after a number of years

Natural history

- symptoms resolve in the majority of patients after 5-10 years
- some patients may be left with hearing loss
- psychological distress is common

Management

- ENT assessment is required to confirm the diagnosis
- patients should inform the DVLA. The current advice is to cease driving until satisfactory control of symptoms is achieved
- acute attacks: buccal or intramuscular prochlorperazine. Admission is sometimes required
- prevention: betahistine may be of benefit

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

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Question 44 of 60

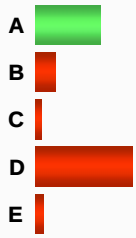
A 44-year-old man asks for advice. He is due to go on a long bus journey but suffers from debilitating motion sickness. Which one of the following medications is most likely to prevent motion sickness?

- A. Cyclizine ✓
- B. Chlorpromazine
- C. Metoclopramide ✗
- D. Prochlorperazine
- E. Domperidone

Next question

Motion sickness - hyoscine > cyclizine > promethazine

Question stats



33.4% of users answered this question correctly

Session score = 77.3%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Motion sickness

Motion sickness describes the nausea and vomiting which occurs when an apparent discrepancy exists between visually perceived movement and the vestibular systems sense of movement

Management

- the BNF recommends hyoscine (e.g. transdermal patch) as being the most effective treatment. Use is limited due to side-effects
- non-sedating antihistamines such as cyclizine or cinnarizine are recommended in preference to sedating preparation such as promethazine

Rate question:

Next question

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Question 45 of 60

A 25-year-old rugby player presents the day following a match. His right ear is signficantly swollen and red. On examination he appears to have an auricular haematoma. What is the most appropriate management?

- A. Take a two-week course of ibuprofen
- B. Apply a compression bandage
- C. Apply an ice-pack six times a day for the next three days
- D. Perform a needle aspiration in surgery
- E. Refer to secondary care

Next question

Auricular haematomas are specifically mentioned in the RCGP curriculum.

Auricular haematomas

Auricular haematomas are common in rugby players and wrestlers. Prompt treatment is important to avoid the formation of 'cauliflower ear'.

Management

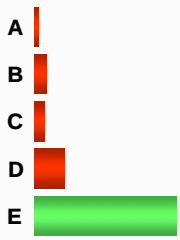
- incision and drainage has been shown to be superior to needle aspiration

Rate question:

Next question

Comment on this question

Question stats



72.1% of users answered this question correctly

Session score = 75.6%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

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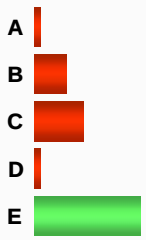
Question 46 of 60

Which one of the following statements regarding Meniere's disease is correct?

- A. More common in patients from the Indian Subcontinent
- B. Symptoms resolve in the majority of patients after 6-12 months
- C. It is very rare that patients develop permanent hearing loss
- D. More common in children
- ✓ E. Approximately equal incidence in males and females

Next question

Question stats



53.7% of users answered this question correctly

Session score = 76.1%

Meniere's disease

Meniere's disease is a disorder of the inner ear of unknown cause. It is characterised by excessive pressure and progressive dilation of the endolymphatic system. It is more common in middle-aged adults but may be seen at any age. Meniere's disease has a similar prevalence in both men and women.

Features

- recurrent episodes of vertigo, tinnitus and hearing loss (sensorineural). Vertigo is usually the prominent symptom
- a sensation of aural fullness or pressure is now recognised as being common
- other features include nystagmus and a positive Romberg test
- episodes last minutes to hours
- typically symptoms are unilateral but bilateral symptoms may develop after a number of years

Natural history

- symptoms resolve in the majority of patients after 5-10 years
- some patients may be left with hearing loss
- psychological distress is common

Management

- ENT assessment is required to confirm the diagnosis
- patients should inform the DVLA. The current advice is to cease driving until satisfactory control of symptoms is achieved
- acute attacks: buccal or intramuscular prochlorperazine. Admission is sometimes required
- prevention: betahistine may be of benefit

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

Comment on this question

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Question 47 of 60

You review a 25-year-old man who has allergic rhinitis. He has been using intranasal oxymetazoline which he bought from the local chemist for the past 10 days. What is the main side-effect of using topical decongestants for prolonged periods?

- A. Permanent loss of smell
- B. Infective sinusitis
- C. Post-nasal drip
- ✓ D. Tachyphylaxis
- ✗ E. Necrosis of the nasal septum

Next question

After using topical decongestants for prolonged periods increasing doses are needed to provide the same effect, a phenomenon known as tachyphylaxis.

The January 2010 AKT feedback report stated 'Increasingly, patients are encouraged to self-manage conditions, perhaps with advice from a pharmacist. *Candida*tes did not perform well with regard to issues related to over the counter medication, such as side-effects and contraindications.'

Allergic rhinitis

Allergic rhinitis is an inflammatory disorder of the nose where the nose become sensitized to allergens such as house dust mites and grass, tree and weed pollens. It may be classified as follows, although the clinical usefulness of such classifications remains doubtful:

- seasonal: symptoms occur around the same time every year. Seasonal rhinitis which occurs secondary to pollens is known as hay fever
- perennial: symptoms occur throughout the year
- occupational: symptoms follow exposure to particular allergens within the work place

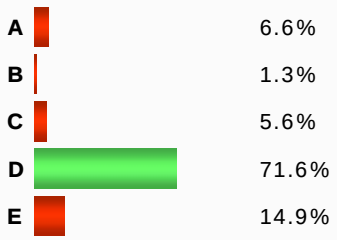
Features

- sneezing
- bilateral nasal obstruction
- clear nasal discharge
- post-nasal drip
- nasal pruritus

Management of allergic rhinitis

- allergen avoidance
- oral or intranasal antihistamines are first line
- intranasal corticosteroids

Question stats



71.6% of users answered this question correctly

Session score = 74.5%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries
Allergic rhinitis guidelines

- course of oral corticosteroids are occasionally needed
- there may be a role for short courses of topical nasal decongestants (e.g. oxymetazoline). They should not be used for prolonged periods as increasing doses are required to achieve the same effect (tachyphylaxis) and rebound hypertrophy of the nasal mucosa may occur upon withdrawal

Rate question:

Next question

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Questions 48 to 50 of 60

Theme: Neck lumps

A Lymphoma
B Tuberculosis
C Reactive lymph nodes
D Cystic hygroma
E Branchial cyst
F Goitre
G Carotid aneurysm
H Pharyngeal pouch
I Thyroglossal cyst
J Cervical rib

For each one of the following scenarios select the most likely diagnosis

48. A 19-year-old man presents with a swelling on the left side of his neck. He has recently had an upper respiratory tract infection. On examination he has a smooth swelling in between the sternocleidomastoid muscle and the pharynx. It is fluctuant but doesn't transilluminate or move during swallowing.

Branchial cyst

Brachial cysts often present during intercurrent upper respiratory tract infection

49. A 28-year-old Bangladeshi woman presents with a three day history of sweats, headache, lethargy and muscle aches. On examination she has bilateral tender swellings in the submandibular region.

Reactive lymph nodes

This patient probably has the 'flu

50. A 17-year-old girl presents with a painless swelling in the neck. She is currently well. A midline, cystic swelling is noted in the region of the hyoid bone. It moves upwards when she swallows or sticks her tongue out.

Thyroglossal cyst

Question stats

Average score for registered users:

48	45.3%
49	40.2%
50	87.9%

Session score = 76%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

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Next question

Neck lumps

The table below gives characteristic exam question features for conditions causing neck lumps:

Reactive lymphadenopathy	By far the most common cause of neck swellings. There may be a history of local infection or a generalised viral illness
Lymphoma	Rubbery, painless lymphadenopathy The phenomenon of pain whilst drinking alcohol is very uncommon There may be associated night sweats and splenomegaly
Thyroid swelling	May be hypo-, eu- or hyperthyroid symptomatically Moves upwards on swallowing
Thyroglossal cyst	More common in patients < 20 years old Usually midline, between the isthmus of the thyroid and the hyoid bone Moves upwards with protrusion of the tongue May be painful if infected
Pharyngeal pouch	More common in older men Represents a posteromedial herniation between thyropharyngeus and cricopharyngeus muscles Usually not seen but if large then a midline lump in the neck that gurgles on palpation Typical symptoms are dysphagia, regurgitation, aspiration and chronic cough
Cystic hygroma	A congenital lymphatic lesion (lymphangioma) typically found in the neck, classically on the left side Most are evident at birth, around 90% present before 2 years of age
Branchial cyst	An oval, mobile cystic mass that develops between the sternocleidomastoid muscle and the pharynx Develop due to failure of obliteration of the second branchial cleft in embryonic development Usually present in early adulthood
Cervical rib	More common in adult females Around 10% develop thoracic outlet syndrome
Carotid aneurysm	Pulsatile lateral neck mass which doesn't move on swallowing

Rate question:

Next question

Comment on this question

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Question 51 of 60

Which one of the following conditions is least associated with nasal polyps?

- A. Wegener's granulomatosis ✓
- B. Kartagener's syndrome
- C. Asthma
- D. Infective sinusitis ✗
- E. Cystic fibrosis

Next question

Question stats

A	53.3%
B	12.6%
C	8.8%
D	16.9%
E	8.4%

53.3% of users answered this question correctly

Session score = 74.5%

Nasal polyps

Around in 1% of adults in the UK have nasal polyps. They are around 2-4 times more common in men and are not commonly seen in children or the elderly.

Associations

- asthma* (particularly late-onset asthma)
- aspirin sensitivity*
- infective sinusitis
- cystic fibrosis
- Kartagener's syndrome
- Churg-Strauss syndrome

Features

- nasal obstruction
- rhinorrhoea, sneezing
- poor sense of taste and smell

Unusual features which always require further investigation include unilateral symptoms or bleeding.

Management

- all patients with suspected nasal polyps should be referred to ENT for a full examination
- topical corticosteroids shrink polyp size in around 80% of patients

*the association of asthma, aspirin sensitivity and nasal polyposis is known as Samter's triad

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

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Question 52 of 60

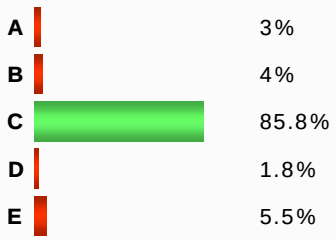
Which one of the following statements regarding trigeminal neuralgia is correct?

- A. Duloxetine is the first-line treatment
- B. All patients with suspected trigeminal neuralgia should be referred to secondary care
- ✓ C. The pain is commonly triggered by touching the skin
- D. The pain is usually constant
- E. It is bilateral in 30% of cases

Next question

The pain is often triggered by light touch, shaving, eating etc. Only around 10% of cases are bilateral.

Question stats



85.8% of users answered this question correctly

Session score = 75%

Trigeminal neuralgia

Trigeminal neuralgia is a pain syndrome characterised by severe unilateral pain. The vast majority of cases are idiopathic but compression of the trigeminal roots by tumours or vascular problems may occur

The International Headache Society defines trigeminal neuralgia as:

- a unilateral disorder characterised by brief electric shock-like pains, abrupt in onset and termination, limited to one or more divisions of the trigeminal nerve
- the pain is commonly evoked by light touch, including washing, shaving, smoking, talking, and brushing the teeth (trigger factors), and frequently occurs spontaneously
- small areas in the nasolabial fold or chin may be particularly susceptible to the precipitation of pain (trigger areas)
- the pains usually remit for variable periods

Management

- carbamazepine is first-line*
- failure to respond to treatment or atypical features (e.g. < 50 years old) should prompt referral to neurology

*the 2010 NICE neuropathic pain guidelines recommend using amitriptyline or pregabalin first-line for non-diabetic neuropathic pain., but makes no specific recommendation for trigeminal neuralgia. Due to the amount of evidence supporting carbamazepine in trigeminal neuralgia and its recommendation in consensus guidelines (including Clinical Knowledge Summaries) the author does not feel that this recommendation should be changed for now

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Rate question:

Next question

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Question 53 of 60

This 21-year-old woman has a history of recurrent epistaxis:

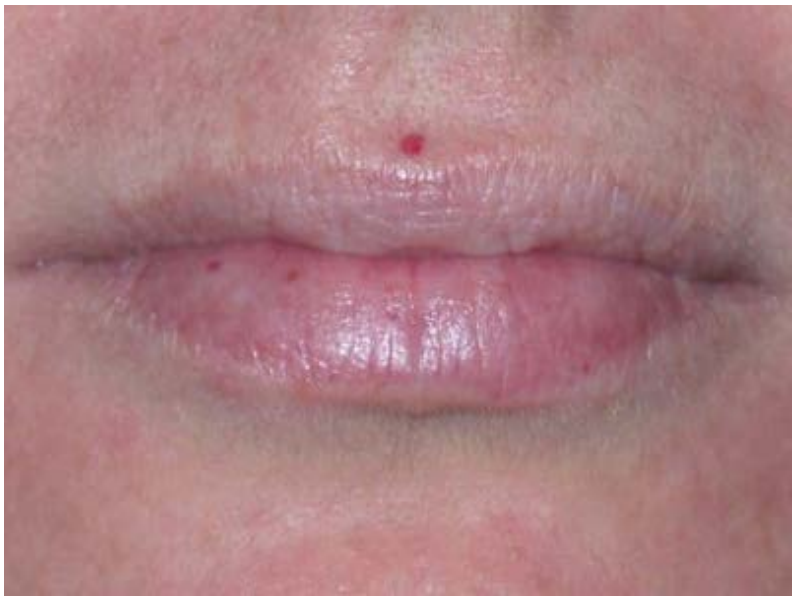

Image used on license from DermNet NZ

What is the most likely underlying diagnosis?

- A. Idiopathic thrombocytopenic purpura
- B. Peutz-Jeghers syndrome
- C. Anorexia nervosa
- D. Combined oral contraceptive pill use
- ✓ E. Hereditary haemorrhagic telangiectasia

Next question

Question stats

A	13.3%
B	17.3%
C	0.5%
D	0.9%
E	68.1%

68.1% of users answered this question correctly

Session score = 75.5%

RCGP curriculum

15.10 - Skin Problems

Knowledge

Curriculum statement

External links

DermNet NZ
Hereditary haemorrhagic telangiectasia

Postgraduate Medical Journal
Review of HHT

Hereditary haemorrhagic telangiectasia

Also known as Osler-Weber-Rendu syndrome, hereditary haemorrhagic telangiectasia (HHT) is an autosomal dominant condition characterised by (as the name suggests) multiple telangiectasia over the skin and mucous membranes. Twenty percent of cases occur spontaneously without prior family history.

There are 4 main diagnostic criteria. If the patient has 2 then they are said to have a possible diagnosis of HHT. If they meet 3 or more of the criteria they are said to have a definite diagnosis of HHT:

- epistaxis : spontaneous, recurrent nosebleeds
- telangiectases: multiple at characteristic sites (lips, oral cavity, fingers, nose)

- visceral lesions: for example gastrointestinal telangiectasia (with or without bleeding), pulmonary arteriovenous malformations (AVM), hepatic AVM, cerebral AVM, spinal AVM
- family history: a first-degree relative with HHT

Rate question:

Next question

Comment on this question

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Question 54 of 60

A patient presents due to a 'brown coating' on his tongue. He is 34-years-old and has no significant medical history. The coating has been present for the past few weeks. He is asymptomatic other than a slight 'tickling' sensation on his tongue.

What is the most likely diagnosis?

- A. Lichen Planus
- B. Oral *Candida*
- C. Iron-deficiency anaemia
- D. Hairy leukoplakia
- ✓ E. Black hairy tongue

Next question

Question stats

A	2%
B	1.4%
C	2.5%
D	27.7%
E	66.4%

66.4% of users answered this question correctly

Session score = 75.9%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Black hairy tongue

Black hairy tongue is relatively common condition which results from defective desquamation of the filiform papillae. Despite the name the tongue may be brown, green, pink or another colour.

Predisposing factors

- poor oral hygiene
- antibiotics
- head and neck radiation
- HIV
- intravenous drug use

The tongue should be swabbed to exclude *Candida*

Management

- tongue scraping
- topical antifungals if *Candida*

Rate question:

Next question

Comment on this question

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Question 55 of 60

Which one of the following viruses is associated with nasopharyngeal carcinoma?

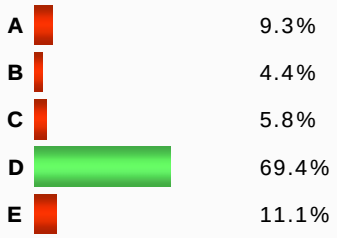
- A. Adenovirus
- B. Rhinovirus
- C. Herpes simplex virus
- ✓ D. Epstein-Barr virus
- E. Picornavirus

Next question

EBV: associated malignancies:

- Burkitt's lymphoma
- Hodgkin's lymphoma
- nasopharyngeal carcinoma

Question stats



69.4% of users answered this question correctly

Session score = 76.4%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

Epstein-Barr virus: associated conditions

Malignancies associated with EBV infection

- Burkitt's lymphoma*
- Hodgkin's lymphoma
- nasopharyngeal carcinoma
- HIV-associated central nervous system lymphomas

The non-malignant condition hairy leukoplakia is also associated with EBV infection.

*EBV is currently thought to be associated with both African and sporadic Burkitt's

Rate question:

Next question

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Question 56 of 60

A 30-year-old man presents with facial pain and a 'heavy head' sensation after having a cold. A diagnosis of acute sinusitis is suspected. Which one of the following should be considered for symptomatic relief?

- ✓ A. Intranasal decongestants
- B. Intranasal corticosteroids
- C. Oral antihistamine
- D. Oral mucolytics
- E. Steam inhalation

Next question

Analgesia is also important. Please see the CKS guidelines for more information.

Question stats

A	40.8%
B	15.7%
C	5.7%
D	1%
E	36.8%

40.8% of users answered this question correctly

Session score = 76.8%

Sinusitis

Sinusitis describes an inflammation of the mucous membranes of the paranasal sinuses. The sinuses are usually sterile - the most common infectious agents seen in acute sinusitis are *Streptococcus pneumoniae*, *Haemophilus influenzae* and rhinoviruses.

Predisposing factors include:

- nasal obstruction e.g. Septal deviation or nasal polyps
- recent local infection e.g. Rhinitis or dental extraction
- swimming/diving
- smoking

Features

- facial pain: typically frontal pressure pain which is worse on bending forward
- nasal discharge: usually thick and purulent
- nasal obstruction: e.g. 'mouth breathing'
- post-nasal drip: may produce chronic cough

Management of acute sinusitis

- analgesia
- intranasal decongestants
- oral antibiotics are not normally required but may be given for severe presentations. Amoxicillin is currently first-line

Management of recurrent or chronic sinusitis

- treat any acute element as above
- intranasal corticosteroids are often beneficial
- referral to ENT may be appropriate

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

Curriculum statement

External links

Clinical Knowledge Summaries
Sinusitis

Rate question:

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Question 57 of 60

During a routine cranial nerve examination the following findings are observed:

Rinne's test: Air conduction > bone conduction in both ears

Weber's test: Localises to the right side

What do these tests imply?

- A. Left conductive deafness
- B. Normal hearing
- C. Right conductive deafness
- D. Right sensorineural deafness
- ✓ E. Left sensorineural deafness

Next question

In Weber's test if there is a sensorineural problem the sound is localised to the unaffected side (right) indicating a problem on the left side

Rinne's and Weber's test

Performing both Rinne's and Weber's test allows differentiation of conductive and sensorineural deafness.

Rinne's test

- tuning fork is placed over the mastoid process until the sound is no longer heard, followed by repositioning just over external acoustic meatus
- air conduction (AC) is normally better than bone conduction (BC)
- if BC > AC then conductive deafness

Weber's test

- tuning fork is placed in the middle of the forehead equidistant from the patient's ears
- the patient is then asked which side is loudest
- in unilateral sensorineural deafness, sound is localised to the unaffected side
- in unilateral conductive deafness, sound is localised to the affected side

Rate question:

Next question

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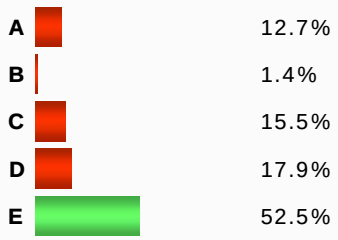
Question stats



52.5% of users answered this question correctly

Session score = 77.2%

RCGP curriculum

15.4 - ENT and Facial Problems

Knowledge

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Questions 58 to 60 of 60

Theme: Facial pain

A Sinusitis
B Dental abscess
C Acute glaucoma
D Temporal arteritis
E Shingles
F Cluster headache
G Trigeminal neuralgia
H Atypical facial pain
I Temporomandibular joint dysfunction
J Parotitis

Question stats

Average score for registered users:

58	84.1%
59	93.9%
60	76.3%

Session score = 76.7%

For each one of the following scenarios select the most likely diagnosis:

58. A 64-year-old woman with a one week history of pain above and lateral to her left eye. On examination she is tender over that area.

Temporal arteritis

59. A 62-year-old woman presents with a two week history of shooting pains across her left cheek. The pain is sometimes triggered by touching her face. She has no past medical history note

Trigeminal neuralgia

60. A 42-year-old man with a 3 month history of chronic cough presents with a persistent headache

Cluster headache

The correct answer is Sinusitis

This patient has chronic sinusitis. The cough is secondary to a post-nasal drip

End session

Facial pain

The table below gives characteristic exam question features for conditions causing facial pain

Condition	Characteristic exam feature
Sinusitis	Facial 'fullness' and tenderness Nasal discharge, pyrexia or post-nasal drip leading to cough
Trigeminal neuralgia	Unilateral facial pain characterised by brief electric shock-like pains, abrupt in onset and termination May be triggered by light touch, emotion
Cluster headache	Pain typical occurs once or twice a day, each episode lasting 15 mins - 2 hours Clusters typically last 4-12 weeks Intense pain around one eye Accompanied by redness, lacrimation, lid swelling, nasal stuffiness
Temporal arteritis	Tender around temples Raised ESR

Rate question:

End session

Comment on this question